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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9711

CERTIFICATE OF DEATH

09700

1. **PLACE OF DEATH** a. COUNTY: Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: 9 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print) First: Florence Middle: H. Last: Baker

4. **DATE OF DEATH** Month: Aug. Day: 17 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 21 – 1892

9. AGE (In years last birthday): 69/5/26

IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James D. Harris

14. MOTHER'S MAIDEN NAME: Elmira Peacock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 223-14-4069

17. **INFORMANT**: M. Cumming J. Baker Address: Snow Hill, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

416X

DUE TO (b): Rheumatic heart disease yrs.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 1961 to Aug 17 1961 that (I) (we) last saw the deceased alive on Aug 17 1961 and that death occurred at 7 PM, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 18, 1961

22c. PHYSICIAN'S NAME (Type): David Rafat, M. D.

22d. ADDRESS: 104 Bay Street, Snow Hill, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 20/61

23c. NAME OF CEMETERY OR CREMATORY: Whatcoat Cemetery

23d. LOCATION (City, town, or county): Snow Hill (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Clay E. Jemmis ADDRESS: Snow Hill, Md

25a. REC'D BY REGISTRAR DATE: AUG 21 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours [illegible] death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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B 1

FOR STATE HEALTH DEPT.

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TO DEPUTY ME[illegible]L EXAMINER: Thi[illegible]tificate should be executed within 24 hours after death. If any [illegible]lay is n[illegible]sary, please execute the ce[illegible]cate, writing the w[illegible] "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to th[illegible]eneral[illegible]tar. Page 4 should be forwarded to the Chief [illegible]edical Examiner's Office along with form PM3. Page 5 may be [illegible]ined fo[illegible] your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09701

1. PLACE OF DEATH a. COUNTY: Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark (Rural)
c. LENGTH OF STAY IN 1b: Was in transit
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill (Rural)
d. STREET ADDRESS: R F D
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Woodrow Middle: Wilson Last: Baker Jr
4. DATE OF DEATH Month: 8 Day: 6 Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 12-1941
9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm hand
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Berlin Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Woodrow Wilson Baker Jr.
14. MOTHER'S MAIDEN NAME: Mildred Brittingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mrs Annah Burbage Address: Berlin, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 825 X
DUE TO (b): Broken neck Internal injuries Shoulder laceration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Auto-accident
INTERVAL BETWEEN ONSET AND DEATH: Brief

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Speeding - estimated over 100 mi per hour
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased driving alone lost control
20c. TIME OF INJURY Hour: 3:15 a.m. ~~p.m.~~ Month, Day, Year: 1961
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town): Newark (County): Worcester (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/8/61
EXAMINER'S NAME (Type): N. E. Sartorius

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/8/61
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial
22d. LOCATION (City, town, or county): Berlin (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: AUG 14 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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TO DEPUTY M[illegible]DICAL EXAMINE[illegible] [illegible]is certificate should be executed within 24 hours after death. [illegible] dela[illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9713

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G293 8/24/61 mb

09703

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin
c. LENGTH OF STAY IN 1b Most of life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin
d. STREET ADDRESS Maple
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Corbin Middle Roscoe Last James

4. DATE OF DEATH Month 8 Day 11 Year 1961

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 17th 1911

9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY Odd jobs

11. BIRTHPLACE (State or foreign country) Sharptown Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME George James

14. MOTHER'S MAIDEN NAME Sarah Ennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No

16. SOCIAL SECURITY NO. 220-09-2804

17. INFORMANT Maggie James Address Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

976X

DUE TO (b) Suicide by firearm (12 guage gun)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH Almost instant.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Heavy drinking of alcohols for 2 or 3 days

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot himself with a shotgun above right ear.

20c. TIME OF INJURY Hour a.m. p.m. 4 Month, Day, Year 19 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

20f. (City or town) Berlin (County) Worcester (State) Md

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE N E Sartorius Sr M.D.

EXAMINER'S NAME (Type) N. E. Sartorius.

Address (Street, city, town, or county) Pocomoke City Md

8/11/61 **DATE SIGNED**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 8-16-61

22c. NAME OF CEMETERY OR CREMATORY Evergreen Cem

22d. LOCATION (City, town, or country) Berlin (State) Md

23. FUNERAL DIRECTOR Booker M West ADDRESS

24a. REC'D BY REGISTRAR DATE AUG 18 '61

24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9714 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09704

1. PLACE OF DEATH a. COUNTY: Worcester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Newark (Rural)
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): /

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: Md b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural – Newark
d. STREET ADDRESS: / RR #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Mary Middle: Elizabeth Last: Hall
4. DATE OF DEATH Month: 8 Day: 24 Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/16/1901
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Del.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mitchell Harmon
14. MOTHER'S MAIDEN NAME: Josephine Harmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: John Hall. Address: Newark, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): A. Coronary disease
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): c Arteriosclerosis + Burns
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Burns of hip followed by a fall.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Contact with a lighted oil stove
20c. TIME OF INJURY Hour a.m. p.m.: 9 Month, Day, Year: Aug [illegible] 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Newark (County): Worcester (State): Md

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): N. E. Sartorius
Address (Street, city, town, or county)
DATE SIGNED: 8/24/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-27-61
22c. NAME OF CEMETERY OR CREMATORY: Harmony Cemetery
22d. LOCATION (City, town, or country): Millsboro (State): Del

23. FUNERAL DIRECTOR: Watson + Gray ADDRESS: Millsboro Del
24a. REC'D BY REGISTRAR DATE: AUG 30 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS. A15ME
5M 7/59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9715

CERTIFICATE OF DEATH

Reg. Dist. No. 09705

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop Rural
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Worcester Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bishop
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First Nancy Middle Showell Last Hall
4. DATE OF DEATH Month Aug. Day 26 Year 1961

5. SEX Female
6. COLOR OR RACE colored
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan. 14, 1878
9. AGE (In years last birthday) 83 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Showell
14. MOTHER'S MAIDEN NAME Mary Ayres

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 212-12-3404
17. INFORMANT Arthur Showell Address Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 7 yrs.
443X
DUE TO (b) Senility
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CVA (old)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 8/28, 1954, to 8/19, 1961, that I last saw the deceased alive on 8/19, 1961, and that death occurred at 2:25 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE Ivory U. Sully Jr. M.D.
ADDRESS (Street, city or town, state) Berlin, Md
DATE SIGNED 8/28/61
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Aug. 29, 1961
22c. NAME OF CEMETERY OR CREMATORY Showell Cem.
22d. LOCATION (City, town, or county) Showell (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Watson ADDRESS Pocomoke City, Md.
24a. REC'D BY REGISTRAR DATE SEP 1 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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FOR STATE HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09706

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.F.D. 2

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
d. STREET ADDRESS: R.F.D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOTTIE Middle JONES Last HUDSON
4. DATE OF DEATH: Month August Day 10 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: unknown
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jack Jones
14. MOTHER'S MAIDEN NAME: Mary Esther Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Henry P. Walters, Address: Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary disease — INTERVAL BETWEEN ONSET AND DEATH: ?
420.1
DUE TO (b) Hypertension — Brief
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity. Found on the floor face down, nose mashed and nose had bled.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE: N E Sartorius Sr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): N. E. SARTORIUS, SR.
Address (Street, city, town, or county)
DATE SIGNED: 8/11/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-12-61
22c. NAME OF CEMETERY OR ~~XXXXXX~~: Union Greenbackville
22d. LOCATION (City, town, or country) (State): Worcester County, Maryland
23. FUNERAL DIRECTOR: Henry H. Watson ADDRESS: Pocomoke City, Md.
24a. REC'D BY REGISTRAR DATE: AUG 14 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

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TO HOSPITAL O[illegible]TENDING PHYSICI[illegible] The law requires that the death certificate be executed within 2[illegible] hours [illegible] death. Page 4 may be retained by the hospital or att[illegible]g physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi[illegible] in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9717

CERTIFICATE OF DEATH

09708

1. **PLACE OF DEATH** a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 44 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) X

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Snow Hill
d. STREET ADDRESS 209 Martin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print) First Littleton Middle David Last Jenkins
4. **DATE OF DEATH** Month Aug Day 9 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 24-1872
9. AGE (In years last birthday) 89/5/15 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill
11. BIRTHPLACE (State or foreign country) Jesterville, Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William J. Jenkins
14. MOTHER'S MAIDEN NAME Emily S. Mason
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. **INFORMANT** Address Mrs Theresa M Jenkins, Snow Hill, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

420.0

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	Minutes
DUE TO (b)	Arteriosclerotic Heart Disease	Years
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Aug 9 1961 to Aug 9 1961 that (I) (we) last saw the deceased alive on Aug 9 1961, and that death occurred at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE David Rafat M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT
22d. ADDRESS Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Aug 11/61
23c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery
23d. LOCATION (City, town or county) Parksley (State) Virginia

24. FUNERAL DIRECTOR'S SIGNATURE Ollay E. Dennis ADDRESS Snow Hill, Md
25a. REC'D BY REGISTRAR DATE AUG 14 61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9718 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09709

M

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Ocean City
c. LENGTH OF STAY IN 1b 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sea Isle Motel

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE VIRGINIA b. COUNTY FLUVANNA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - FORK UNION
d. STREET ADDRESS 83X-3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First GESSNER Middle HARRISON Last JONES
4. DATE OF DEATH Month Aug Day 5 Year 1961

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 9 1882
9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE Agent
10b. KIND OF BUSINESS OR INDUSTRY INSURANCE
11. BIRTHPLACE (State or foreign country) FORK UNION, VA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Walter Campbell Jones
14. MOTHER'S MAIDEN NAME Edwina Chandler

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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT MRS DORA JONES (WIFE) Address FORK UNION VIRGINIA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion Acute — INTERVAL BETWEEN ONSET AND DEATH 4 hours
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive CVD — 2 years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE F J Townsend Jr M.D.
EXAMINER'S NAME (Type) FRANCIS JAMES TOWNSEND ~~Asst~~ JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Ocean City Md
DATE SIGNED Aug 5, 61.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF AUG. 7, 1961
22c. NAME OF CEMETERY OR CREMATORY FORK UNION MEMORIAL
22d. LOCATION (City, town, or country) FORK UNION (State) VA.

23. FUNERAL DIRECTOR Anna A. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE AUG 8 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05710

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin
c. LENGTH OF STAY IN 1b 17 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route #3

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin
d. STREET ADDRESS Route # 3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Rachael Middle Madeline Last Jones

4. DATE OF DEATH Month 8 Day 22 Year 1961

5. SEX F
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH 2/19/1917
9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Jones
14. MOTHER'S MAIDEN NAME Mary Hester Showell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 213-24446
17. INFORMANT James Thomas Jones - (a brother) Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary disease
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH Hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) N. E. Sartorius
Address (Street, city, town, or county)
DATE SIGNED 8/22/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-26-61
22c. NAME OF CEMETERY OR CREMATORY NEW BETHEL CEM.
22d. LOCATION (City, town, or country) BERLIN, Md. (State)

23. FUNERAL DIRECTOR Jolley Stewart ADDRESS Salisbury, Md
24a. REC'D BY REGISTRAR DATE AUG 30 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Knott

THORNTON B. Jolley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9720

CERTIFICATE OF DEATH

09711

1. PLACE OF DEATH
a. COUNTY Worcester
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Roanoke Island
c. LENGTH OF STAY IN 1b 21 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shepherd Bay

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Snow Hill
d. STREET ADDRESS Bay Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

X

3. NAME OF DECEASED (Type or print) First Nelson Middle Omory Last Lewis

4. DATE OF DEATH Month Aug Day 21 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Nov. 6 - 1897

9. AGE (In years last birthday) 63/9/15
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Farmer

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11. BIRTHPLACE (County & State, or foreign country) Chincoteague, Va

12. CITIZEN OF WHAT COUNTRY?

I

13. FATHER'S NAME Omory Lewis

14. MOTHER'S MAIDEN NAME Annie Lister

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO. 215-36-1851

17. INFORMANT Mrs Elodie Lewis Address Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH 1 hr.

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

8

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1950 to Aug 21, 1961, that (I) (we) last saw the deceased alive on Aug 15 1961, and that death occured at 6:15 PM from the causes and on the date stated above.

22a. SIGNATURE Paul Cohen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) PAUL COHEN

22d. ADDRESS Snow Hill, Md

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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

23b. DATE THEREOF Aug. 24/61

23c. NAME OF CEMETERY OR CREMATORY J. William Lee's Son

23d. LOCATION (City, town or county) Washington (State) D.C.

24. FUNERAL DIRECTOR'S SIGNATURE Clay E. Dennis ADDRESS Snow Hill, Md

25a. REC'D BY REGISTRAR DATE AUG 24 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITA[illegible]**R ATTENDING** [illegible]**SICIAN:** The law requires that the death certificate be ex[illegible]d wi[illegible]4 hours after death. Page 4 may be retained by [illegible]spital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9721

CERTIFICATE OF DEATH

09712

Items 8 & 9 Film G294 9/7/61 Jwk

1. PLACE OF DEATH
a. COUNTY: Worcester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bishopville
c. LENGTH OF STAY IN 1b: 20 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): XXXX

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bishopville
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: EMMA Middle: Last: MUMFORD

4. DATE OF DEATH Month Day Year: Aug. 24, 1961 19

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1908 Feb. 4, 1907
9. AGE (In years last birthday): 53 54 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lemuel Showell
14. MOTHER'S MAIDEN NAME: Laura Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes give war or dates of service) ✓
16. SOCIAL SECURITY NO. ✓
17. INFORMANT: Henry Mumford Address: Bishopville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO (b): Hypertensive Cardiovascular Disease — 4 yrs 5 mos
DUE TO (c):

442x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-18, 1957 to 8/17, 1961, that (I) (we) last saw the deceased alive on 8/17 1961, and that death occured at 5:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Ivory V. Sully, Jr. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/25/61
22c. PHYSICIAN'S NAME (Type): IVORY V. SULLY, Jr, MD
22d. ADDRESS: BERLIN

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/26/61
23c. NAME OF CEMETERY OR CREMATORY: Evergreen
23d. LOCATION (City, town or county) (State): Berlin, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Selbyville, Del,
25a. REC'D BY REGISTRAR DATE: AUG 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITA[illegible]R ATTENDING [illegible]SICIAN: The law requires that the death certificate be ex[illegible]d w[illegible]24 hours after death. Page 4 may be retained by [illegible]spital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9722

CERTIFICATE OF DEATH

09713

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City
c. LENGTH OF STAY IN 1b 3 Mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plimhimmon Hotel

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS Ocean City Blvd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILDA Middle MASTER Last PHILLIPS
4. DATE OF DEATH Month 8 Day 17 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Apr.20,1883
9. AGE (In years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Clerk
10b. KIND OF BUSINESS OR INDUSTRY Hotel
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Phillips
14. MOTHER'S MAIDEN NAME Elizabeth Darby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknow (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Louise P. Rogan, Address New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
420.1
DUE TO
(b) Coronary artery disease
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-17 1961 to 8-17 1961 that (I) (we) last saw the deceased alive on 8-17 1961, and that death occurred at 8:20 PM from the causes and on the date stated above.

22a. SIGNATURE A C Smoot Jr M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 8-18-61
22c. PHYSICIAN'S NAME (Type) A. C. Smoot, Jr.
22d. ADDRESS Peninsula Gen Hosp. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 8-20-1961
23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery
23d. LOCATION (City, town, or county) (State) Mardela, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Co. Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE AUG 21 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus.

TO HOSPITAL O[illegible]**TENDING PHYSICIA**[illegible] The law requires that the death certificate be executed within [illegible] hours a[illegible] death. Page 4 may be retained by the hospital or atte[illegible] physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi[illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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BP

VR A15 (4)
15M 9/59

Norman F. Baker

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FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, [illegible] please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09714

~~Item 8 Film G293 8/29/61 jwk~~

1. PLACE OF DEATH a. COUNTY: Worcester MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: Md b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City (Rural)
d. STREET ADDRESS: Box-2 R.F.D. #1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Isaac Middle: Last: Waters

4. DATE OF DEATH Month: 8 Day: 16 Year: 1961

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1903 12/25/1904

9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Milling Canning

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathaniel Waters

14. MOTHER'S MAIDEN NAME: Sarah Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-22-9253

17. INFORMANT: Harry Waters Address: Pocomoke City Md RR 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia
322.1
DUE TO (b): Flooding of Oesophagus, Mouth & Nose with food
DUE TO (c): Chronic Alcoholic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: N. E. Sartorius Sr. MD M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): N. E. Sartorius Pocomoke City Md.
Address (Street, city, town or county)

DATE SIGNED: 8/17/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-20-61
22c. NAME OF CEMETERY OR CREMATORY: Tindley Chapel
22d. LOCATION (City, town, or country) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR: Edgar Wharton ADDRESS: New Church, Va.

24a. REC'D BY REGISTRAR DATE: AUG 22 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

BP

VS. A15ME
5M 7/59